

Module 13: Claims & Appeals

Module Objectives

After this module, you should be able to:

- Identify claim basics and where to submit claims
- Recognize who is responsible for filing the claim
- Identify the four appeal types
- Describe what can and cannot be appealed



Claim Basics

- Claims are filed to issue payment for services or supplies provided by civilian sources of medical care
- The person who submits the claim is either the provider of services or supplies, or the beneficiary
 - Only authorized providers can submit claims for reimbursement
 - An authorized provider is one approved under TRICARE for services or supplies provided to a beneficiary and who receives payment directly from TRICARE
 - Any TRICARE-eligible beneficiary can submit a claim for reimbursement



Submitting Claims

- Claims are submitted to the claims processor responsible for the region in which the beneficiary lives or is enrolled
- There are two major TRICARE medical claims processors:
 - **Palmetto Government Benefits Administration (PGBA)**
handles claims for the North and South regions
 - **Wisconsin Physicians Service (WPS)** handles claims for the West and Overseas regions, as well TRICARE for Life claims (regardless of stateside region)
- If a claim is sent to the wrong claims processor, the claim is either forwarded to the correct processor or returned to either the provider or beneficiary



Who is Responsible for Filing the Claim?

- Beneficiaries are responsible for ensuring claims are submitted and processed, no matter who submits the actual claim
- If the beneficiary sees a network provider, the provider is responsible for filing the claim
- If the beneficiary sees a non-network provider, the provider can choose to participate or not:
 - Participating providers may submit claims for beneficiaries, but are not required
 - Non-participating providers are not required to file and may choose not to submit a claim for the beneficiary
- Beneficiaries should ask and verify that their civilian providers will file the claim on the beneficiary's behalf



Claim Filing

- A claim form should be submitted for each individual provider that rendered services
- A claim should be submitted for each family member that received services, regardless of whether they all visited the same provider on the same day
- Filing deadline: Within one (1) year of the date of service



Other Health Insurance (OHI)

- If a beneficiary has OHI, the beneficiary or the provider must file a claim with that health insurance plan before filing with TRICARE
- After it has been processed by the OHI, a claim can then be filed with TRICARE along with a copy of:
 - The other health plan's payment determination
 - The itemized charges (bill)
- Beneficiaries should notify their regional contractor or their claims processor about their OHI or any OHI changes to avoid delay in processing claims or possible denials



Explanation of Benefits (EOB)

- After submitting claims, the beneficiary and provider each receive an EOB from the claims processor, within six weeks, showing the services performed and the claim adjudication (or settlement of payments)
- Beneficiaries should carefully check each EOB they receive to compare their bills from the provider or service against the EOB
- Beneficiaries should contact their claims processor if they receive charges for a service they never received
- Beneficiaries should submit claims for any services received but not submitted by their provider



Appeals

- By submitting a letter of appeal, the beneficiary is asking the TRICARE contractor or TRICARE Management Activity (TMA) for review of an authorization or claims denial
- There are four types of appeals:
 - **Medical Necessity** - Based on whether the care is appropriate, reasonable, and adequate for the beneficiary's condition
 - **Factual Determination** - Factual determinations involve issues such as coverage, provider authorization (status) requests, or denial of a provider's request for approval as a TRICARE provider
 - **Dual-eligible beneficiary (Medicare-TRICARE eligible beneficiaries)** - When Medicare and TRICARE have both denied a claim and the beneficiary has successfully appealed the Medicare claim (Medicare paid the claim), the beneficiary can then appeal the TRICARE denial
 - **Provider Sanction** - When a provider has been denied approval as an authorized TRICARE provider or who has been terminated, excluded, suspended, or otherwise sanctioned
- The appeals process varies, depending on which type of appeal is submitted, but all initial denials and appeal denials explain how, where, and the timeframe in which to file the next level of review



What Can Be Appealed

- Diagnosis
- Necessity to be an inpatient
- Denial of preauthorization for services, including mental health
- Termination of treatments or services that have been previously authorized
- Denial of TRICARE payment for services or supplies received
- Termination of TRICARE payment for continuation of services or supplies that were previously authorized
- Denial of a provider's request for approval as a TRICARE-authorized provider or expelling a provider from TRICARE



What Cannot Be Appealed

- The amount of the TRICARE determined costs or charges for a particular medical service
- The decision by TRICARE, or its contractors, to ask the beneficiary for more information before taking action on the beneficiary's claim or appeal request
- Beneficiaries cannot appeal decisions relating to the status of TRICARE providers
- Decisions relating to eligibility as a TRICARE beneficiary



You've Completed Module 13: Claims and Appeals

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